

SHORT TITLE: Insurance portability; emergency.

STATE OF OKLAHOMA

1st Session of the 46th Legislature (1997)

SENATE BILL NO. 194

By: Hendrick

AS INTRODUCED

An Act relating to insurance; amending 36 O.S. 1991, Sections 4424, as amended by Section 1, Chapter 136, O.S.L. 1993, 4426, as last amended by Section 8, Chapter 294, O.S.L. 1994, Section 2, Chapter 244, O.S.L. 1995, and Section 3, Chapter 304, O.S.L. 1992, as last amended by Section 1, Chapter 224, O.S.L. 1995 (36 O.S. Supp. 1996, Sections 4424, 4426, 4426.2 and 4509.2), which relate to long-term care insurance and acceptance of insurance coverage by succeeding employer; expanding definitions; providing for refund of certain premium within certain time frame; expanding requirements for content of certain outline; requiring delivery of certain contract or certificate within certain time period; stating requirements related to certain denial; specifying contents of certain benefits; providing for certain refund under certain circumstances; requiring certain employer to accept certain coverage under certain circumstances; increasing amount of time allowed for certain application; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 36 O.S. 1991, Section 4424, as amended by Section 1, Chapter 136, O.S.L. 1993 (36 O.S. Supp. 1996, Section 4424), is amended to read as follows:

Section 4424. Unless the context requires otherwise, the definitions in this section apply throughout the Long-Term Care Insurance Act, Section 4421 et seq. of this title.

1. a. "Long-term care insurance" means any insurance policy or rider, including qualified long-term care insurance contracts, which are advertised, marketed, offered or designed primarily to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital.
- b. This term includes group and individual health policies or riders or group and individual life policies or annuities or riders which provide, directly or as a supplement, coverage for long-term care, whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, life care communities, or any similar organization.
- c. This term also includes a policy or rider which provides for payment of long-term care benefits based upon cognitive impairment or the loss of functional capacity.
- d. Long-term care insurance shall not include any insurance policy which is offered primarily to provide

basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage or related asset-protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

- e. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.
- f. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this act.

2. "Applicant" means:

- a. in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, and
- b. in the case of a group long-term care insurance policy, the proposed certificate holder.

3. "Certificate" means any certificate issued under a group long-term care insurance policy, which certificate has been delivered, or issued for delivery, in this state.

4. "Group long-term care insurance" means a long-term care insurance policy which is delivered, or issued for delivery, in this state and issued to:

- a. one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof or for members or former members, or a combination thereof, of the labor organizations, or
- b. any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (1) is composed of individuals, all of whom are or were actively engaged in the same profession, trade or occupation, and
 - (2) has been maintained in good faith for purposes other than insurance, or
- c. an association, a trust, or the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Insurance Commissioner that the association or associations shall have at the outset of transacting long-term care insurance in this state a minimum of one hundred (100) persons in the association or associations and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least one (1) year;

and shall have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. Thirty (30) days after such filing the association or associations shall be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements, or

d. a group other than as described in subparagraphs a, b and c of this paragraph, subject to a finding by the Commissioner that:

- (1) the issuance of the group policy is not contrary to the best interest of the public,
- (2) the issuance of the group policy would result in economies of acquisition or administration, and
- (3) the benefits are reasonable in relation to the premiums charged.

5. "Life care community" means any arrangement pursuant to which a person contracts for a place of residence and personal care services, including but not limited to services which progress from independent living to semi-dependent nursing care to acute nursing care, in consideration of a payment or payments of fees prior to the delivery of services and accommodations. Life care community shall not include traditional residential landlord and tenant agreements utilizing periodic rental and security deposit payments.

6. "Policy" means any policy, contract, certificate, subscriber agreement, rider or endorsement delivered, or issued for delivery,

in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, life care community, or any similar organization.

7. "Qualified long-term care insurance contract" means any individual or group insurance contract if it meets the requirements of Section 7702(b) of the Internal Revenue Code, as amended, and if:

- a. the only insurance protection provided under the contract is coverage of qualified long-term care services,
- b. the contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount,
- c. the contract is guaranteed renewable,
- d. the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract, and
- e. the contract contains the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code.

8. "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating,

and rehabilitative services, and maintenance for personal care services for which an insured is eligible under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

SECTION 2. AMENDATORY 36 O.S. 1991, Section 4426, as last amended by Section 8, Chapter 294, O.S.L. 1994 (36 O.S. Supp. 1996, Section 4426), is amended to read as follows:

Section 4426. A. No long-term care insurance policy shall:

1. Be canceled, nonrenewed, or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder;

2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

B. 1. No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

2. No long-term care insurance policy or certificate shall exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

3. The definition of "preexisting condition" does not prohibit an insurer:

- a. from using an application form designed to elicit the complete health history of an applicant, and
- b. from underwriting, on the basis of the answers on that application, in accordance with that insurer's established underwriting standards.

4. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph 2 of subsection B of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph 2 of subsection B of this section.

C. Prior hospitalization/institutionalization:

1. No long-term care insurance policy may be delivered or issued in this state if such policy:

- a. conditions eligibility for any benefits on a prior hospitalization requirement,
- b. conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care, or
- c. conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

2. a. A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or

Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

- b. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

D. No law, rule or regulation shall establish loss ratio standards for long-term care insurance policies unless a specific reference to long-term care insurance policies is contained in such law, rule or regulation.

E. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days after its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied with the policy, for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page of the policy or attached thereto, stating in substance, that the applicant shall have the right to return the policy or certificate within thirty (30) days after its delivery and to have the premium refunded if, after examination of the policy, or certificate, the applicant is not satisfied with the policy, for any reason. If an application for a qualified long-term care contract is denied, the issuer shall refund to the applicant any premium and any other fees submitted by the applicant within thirty (30) days of the date of the denial. If the insurer does not return any premiums or moneys paid therefor within thirty (30) days from the date of cancellation, the insurer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year, as certified to the Insurance Commissioner by the State Treasurer on the first

regular business day in January of each year, plus two (2) percentage points, which shall accrue from the date of cancellation until the premiums or moneys are returned. In such event, the long-term care policy shall be deemed to have been canceled on the date the policy was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery of such policy or annuity to the insurer.

F. An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose. The Insurance Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage. In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form. Such outline of coverage shall include, but not be limited to:

1. A description of the principal benefits and coverage provided in the policy;

2. A statement of the principal exclusions, reductions and limitations contained in the policy;

3. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of group coverage shall be specifically described;

4. A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

5. A description of the terms under which the policy or certificate may be returned and premium refunded; ~~and~~

6. A brief description of the relationship of cost of care and benefits; and

7. If the policy or certificate is intended to be a qualified long-term care insurance contract, a statement that discloses to the policyholder or certificate holder that the policy is intended to be a qualified long-term care insurance contract.

G. The issuer of a qualified long-term care insurance contract shall deliver to the applicant, policyholder, or certificate holder the contract or certificate no later than thirty (30) days after the date of approval.

H. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

1. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

2. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

3. Any exclusions, reductions and limitations on benefits of long-term care; and

4. If applicable to the policy type, the summary shall also include:

a. a disclosure of the effects of exercising other rights under the policy,

b. a disclosure of guarantees related to long-term care costs of insurance charges, and

c. current and projected maximum lifetime benefit.

~~H.~~ I. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

1. Any long-term care benefits paid out during the month;

2. An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

3. The amount of long-term care benefits existing or remaining.

J. If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

1. Provide a written explanation of the reasons for the denial;

and

2. Make available all information directly related to such denial.

~~I.~~ K. No policy shall be advertised, marketed or offered as long-term care insurance unless it complies with the provisions of the Long-Term Care Insurance Act.

~~J.~~ L. Policies or contracts issued by life care communities which are not licensed insurers in this state shall contain the following statement in conspicuous bold-face type on the front of the policy or contract: "The financial condition of the entity issuing this contract is not subject to review by or the jurisdiction of the Oklahoma Insurance Commissioner. This contract is not subject to the protection of any guaranty association."

SECTION 3. AMENDATORY Section 2, Chapter 244, O.S.L. 1995 (36 O.S. Supp. 1996, Section 4426.2), is amended to read as follows:

Section 4426.2 A. 1. No insurer may offer a long-term care insurance policy unless the insurer also offers to the applicant the option to purchase a policy that provides for nonforfeiture benefits.

2. This section shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

3. For certificates issued on or after the effective date of this act, under a group long-term care insurance policy as defined in Section 4424 of Title 36 of the Oklahoma Statutes, which policy was in force at the time this act became effective, the provisions of this section shall not apply.

B. The Insurance Commissioner shall promulgate rules which are consistent with the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulation and which specify the types of nonforfeiture benefits to be included in policies and certificates, the standards for the benefits, and the date nonforfeiture benefits must commence.

C. 1. For purposes of this section, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefit amounts and frequency in effect at the time of lapse, but not increased thereafter, shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph ~~2~~ 3 of this subsection.

2. Nonforfeiture benefits for qualified long-term care insurance contracts shall include at least a reduced paid-up insurance benefit, an extended term insurance benefit, the offer of a shortened benefit period, or other similar offerings approved by the Secretary of the U.S. Treasury, and shall be provided as

specified in regulations. The issuer of such a contract may refund premiums upon the death of the insured or upon complete surrender or cancellation of the contract or policy, as long as the refund does not exceed the aggregate premiums paid for the contract or policy.

3. The standard nonforfeiture credit shall be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation set forth in subsection D of this section.

~~3.~~ 4. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

~~4.~~ 5. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

D. All benefits paid by the insurer while the policy or certificate is in premium paying status and in paid-up status shall not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

SECTION 4. AMENDATORY Section 3, Chapter 304, O.S.L. 1992, as last amended by Section 1, Chapter 224, O.S.L. 1995 (36 O.S. Supp. 1996, Section 4509.2), is amended to read as follows:

Section 4509.2 A. When an individual or a dependent who was covered ~~as an employee or dependent under a group health insurance plan provided through an employer~~ by individual or group insurance pursuant to the provisions of the Health Insurance Portability and

Accountability Act of 1996, Public Law 104-191, gains employment with an employer who provides for health insurance through a group plan or applies for individual insurance, the succeeding carrier of the succeeding employer shall accept the individual and dependents of the individual who were covered under the group plan of an employer prior coverage and shall not apply preexisting conditions limitations or exclusions of preexisting conditions or apply waiting period requirements for the individual employee insured or the dependents of the employee insured beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled. Provided; provided, however, the individual employee insured and any dependents of such individual must apply for the new coverage for the employee and any dependents desiring coverage within thirty-one (31) sixty-three (63) days following the date of eligibility for participation in the plan in accordance with the employment or personnel policies of the employer for participation or prior to termination of coverage elected pursuant to the provisions of the Combined Omnibus Budget Reconciliation Act (COBRA), 26 U.S.C. Section 4980B(f), whichever comes later termination of prior creditable coverage.

B. When there is a lapse in the coverage of the individual employee insured or a dependent of the individual employee insured provided for by subsection A of this section for any reason other than a probationary period or similar waiting period imposed by the employment or personnel policies of an employer, the provisions of subsection A of this section shall not apply to the person whose coverage lapsed.

SECTION 5. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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CJ